

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 3 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10866

Registration District No. 287

Primary Registration District No. 5407

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Rural (Cotton Hill)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community
years, months or days) 53 4

3. (c) PRINT
FULL NAME

Sarah Paul Henson

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Female

5. Color or
race White

6. (a) Single, widowed, married,
divorced married

6. (b) Name of husband or wife

Robert Henson

7. Birth date of deceased

June 25 1851
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

89

7

23

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

at home (son)

11. Industry or business

none

12. Name

D K

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

D K

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

L. G. Stocker

(b) Address

Malden Mo R 9

17. (a) Buried

(b) Date thereof

2-19-40

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Stevens Cemetery

18. (a) Signature of funeral director

Irby Funeral Service

(b) Address

L. 994th Ave

19. (a) 2/18/40

(b) S. E. Mitchell

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18
year 1940 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from
Feb 13 - 1940 to Feb 18 1940
that I last saw her alive on Feb 17
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchial Pneumonia

Duration

Feb 11

Due to

influenza

Due to

HW

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓

Of autopsy ✓

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
2625

While at work?

(Specify type of place)

(e) Means of injury ✓

23. Signature

F. J. Davidson

Address

St. Louis

Date signed Feb 18

RECEIVED

District Health Officer No. 2,

District File Number 440-876

Date Filed 4/5/4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10866**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **289**

Primary Registration District No. **3487**

Registrar's No. **23**

1. PLACE OF DEATH:

- (a) County **Dunklin**
(b) City or town **Calton Hill**
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify whether

In this community
years, months or days)

3. (a) PRINT
FULL NAME

Sarah Paralee Henson

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex **7**

5. Color or
race **W**

6. (a) Single, widowed, married,
divorced **m**

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if
alive. year

7. Birth date of deceased. **June 25 1857**
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

89

7

23

hr. min.

9. Birthplace (City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

- MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county)

(State or foreign country)

16. (a) Informant

- (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County

- (c) City or town (If outside city or town limits write "RURAL")

- (d) Street No. (If rural, give location)

- (e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **18**
year **1940** hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h. alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Braydon Carlstrom** (Signature of other)
Address **Madden** signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-1186P
1940